

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 286

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Rural Palmyra  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County St. Mary'sCity or town Rural Palmyra  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Peter Andrew Altorf

## 3. (b) Social Security Number

218-24-01024. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Eva Fran Altorf6. (c) If alive, give age 5-8 years7. Birth date of deceased (mo., day, yr.) 8-24-918. AGE: Years 42 Months 4 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation mathematical clerk

## 11. Industry or business

12. Name August Altorf13. Birthplace Switzerland14. Maiden name Josephine Altorf15. Birthplace Switzerland16. Informant Wm. S. Her SmithAddress Palmyra17. burial Date thereof 9-29-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lacey ParkLocation Bushy Mt18. Funeral director W.C. Matheys IncAddress Madison19. 9-22 1948 Paul W. Palmer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948, at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-22 1948 to 9-22 1948and that I last saw him alive on 9-22 1948Immediate cause of death acute indigestionDue to over eating

Due to \_\_\_\_\_

Other conditions Diabetes

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Rollin V. PalmerAddress overmount Date signed 9-22-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

OCT 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

46 f 09658

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Mary's  
 City or town Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Martha Barber

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1873  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wisconsin  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name August Hilke13. Birthplace Wisconsin14. Maiden name Charlotte Peak15. Birthplace Germany16. Informant William B. ChallenAddress Leonardtown, Md.

17. Burial Date thereof 10-9-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. AndrewsLocation Leonardtown18. Funeral director P. B. RobinsonAddress Leonardtown, Md.19. 9/17 1948 Cumali

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948 at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 48, to Sept. 7 19 48, and that I last saw him alive on Sept. 7, 1948

Immediate cause of death

DURATION

Carcinoma Lungs ?

Due to

Due to

Other conditions metastatic to b.i. track

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Aloysius C. Welch M.D.

M. D. or other

Address Date signed 9/17/48

RECEIVED

SEP 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09659

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town near California Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County St. Mary's  
 City or town near California  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Margaret E. Bennett

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife William J. Bennett  
 7. Birth date of deceased (mo., day, yr.) Oct 15 - 1870 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 77 Months 10 Days 24 If less than one day hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace California St. Mary's Md  
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business same

12. Name John A. B. Sherrantine

13. Birthplace St. Mary's Co., Md.

14. Maiden name Maria A. Sanner

15. Birthplace St. Mary's Co., Md.

16. Informant Mrs. Myrtle B. Foote

Address 1112 North Edgewood St. Arlington Va

17. Burial Date thereof Sept 10 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cheneyor cemetery

Location California Maryland

18. Funeral director W.C. Matthews, Sons

Address Leonardtown Maryland

19. Sept. 8 19 48 SG Bean MD  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 19 48 at 6.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to Sept 7 19 48

and that I last saw him alive on Sept 7 19 48

Immediate cause of death \_\_\_\_\_ DURATION

Chronic myocarditis 2 years

Due to interstitial hepatitis 5 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

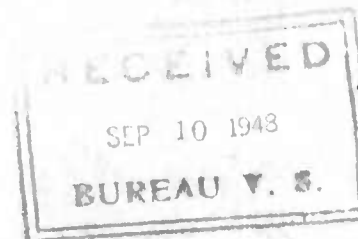
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE SG Bean MD M.D. or other

Address Great Mills, Md Date signed 9-8-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09660

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Leonardtown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Beachville, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male colored married6. (b) Name of husband or wife Susan Caswell

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 59 years

8. AGE:

Years

Months

Days

It less than one day

6918799. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9-22-48  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 9-21

(Date rec'd by registrar)

19 48Camalier

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 48 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 10 19 48, to Sept. 18 19 48and that I last saw him alive on September 17 19 48

Immediate cause of death

DURATION

Myocardial Failure 3 days  
 Due to Chronic Hypertension w/ H. Tremia over 10 days  
Advanced Hyperchronic Anemia not known  
 Due to Malignant Tumor of lower  
 Other conditions Thoracic Spine ca 1 year

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Robert V. Fuchs, M.D.

M. D. or other

Address Leonardtown, Md. Date signed 9/18/48

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SEP 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09661

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Madol Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Marys  
 City or town Madol  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. —  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Joan Jane Burtis  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 1890  
 8. AGE: Years 58 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Marys  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_  
 12. Name Louis Burtis  
 13. Birthplace St. Marys  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_

16. Informant Julius Burtis  
 Address Madol Md  
 17. Burial Date thereof Sept 27-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sacred Heart  
 Location Baltimore Md  
 18. Funeral director W.C. Mattingley Sons  
 Address Leonardtown Md  
 19. Sept 26 19 48 J.A. Camalier  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 19 48 at 5 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 19 48 to Sept 24 19 48  
 and that I last saw him alive on Sept 17 19 48

Immediate cause of death Pulmonary paralysis DURATION 6 hrs

Due to Carcinoma of skin with metastasis 6 months

Due to \_\_\_\_\_

Other condition Irreducible Hernia

(Include pregnancy within 8 months of death)

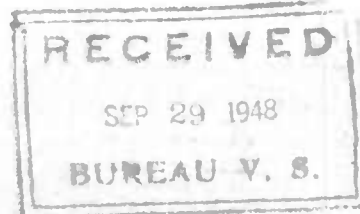
Major findings of operations none  
none Date of op. none

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm D Boyd M.D.  
 Address Leonardtown Md Date signed 9/25/48

1891  
28  
1441



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09662

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH: St. Marys  
 County Route 75 Leonardtown, Md.  
 City or town Rural Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County ST. Marys  
 City or town Lexington, Park, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 45 Renell Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.

## 3. (a) FULL NAME

Joseph Edward Dodge

## 3. (b) Social Security Number

219-12-3027

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife.  
 7. Birth date of deceased (mo., day, yr.) June 30, 1927  
 8. AGE: Years 21 Months 0 Days 0 It less than one day 0 hrs. 0 min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation Seaman  
 11. Industry or business Merchant Marine  
 12. Name Clarence S. Dodge  
 13. Birthplace Washington, D.C.  
 14. Maiden name Edna M. Dodge  
 15. Birthplace Washington, D.C.

16. Informant Edna M. Dodge  
 Address Lexington, Park, Md.  
 17. Burial Date thereof 9/24/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Clivet  
 Location Washington, D.C.  
 18. Funeral director P. B. Robinson  
 Address Leonardtown, Maryland

19. 9-22-48 Registrar Camalier  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

30

20. DATE OF DEATH September 21, 1948, at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1948 to 1948, and that I last saw him alive on dead when first seen

Immediate cause of death Intercranial Hemorrhage DURATION 1 hour  
 Due to Automobile accident  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 9/21/48  
 Where did injury occur? Rural (Leonardtown, Md.) (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) State road  
 Means of injury Collision Injured at work? no

23. SIGNATURE F. J. [Signature] M.D.  
Thomson 9/22/48  
 Address

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7

**RECEIVED**  
SEP 27 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Route 249 St. George's Island, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

USN Ambulance enroute to USNAS, P. R. Md.

How long in hospital or institution?

## 3. (a) FULL NAME

GRANT, Brian Walter

4. Sex

Male

5. Color of race

White

6. (d) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7-9-1928

8. AGE:

20215

If less than one day

.....hra. ....min.

9. Birthplace Superior, Wisconsin  
(Town, county, and state)10. Usual occupation USN

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown16. Informant R. R. Bonar, MC, USN LtComdr.

Address

USNAS, Patuxent River, Md.17. Autopsy  
(Burial, cremation, or removal. Which?)Date thereof 9-27-48  
(month) (day) (year)

Cemetery or crematory

Location

Superior Wisconsin

18. Funeral director

Address

P. B. Robinson  
Lanardtown Md19. 9/27 1948  
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

No

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 September 1948, at 2115 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., 10....., 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death Strangulation

DURATION

InstantDue to Compression of throatDue to Automobile accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Consummate with diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-24-48Where did injury occur? Route 249 St. George's Is. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway

Means of injury

Automobile

Injured at work?

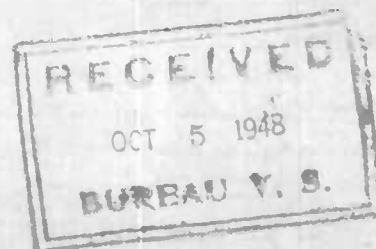
23. SIGNATURE R. R. Bonar, MC USN LtComdr.

M. D. or other

Address USNAS, Patuxent River, Md. Date signed

1948-9-24  
20-2-15-

1928-7-9



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St Marys  
 City or town Leonardtown Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
Leonardtown Maryland  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys  
 City or town Holly Wood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rt. 1  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

John W. Greenwell

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Cladys Greenwell

7. Birth date of deceased (mo., day, yr.) Sept 2 - 1875

8. AGE: Years 73 Months 16 Days 16 hrs. 16 min. 16

9. Birthplace Holly Wood St Mary Md  
 (Town, county, and state)

10. Usual occupation Widow

11. Industry or business same

12. Name William J. Greenwell

13. Birthplace St Marys Co

14. Maiden name Laura Ann. Redman

15. Birthplace St Marys Co

16. Informant James J. Greenwell

Address Holly Wood Md

17. Burial Date thereof Sept 21 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Johns Cemetery

Location Holly Wood Maryland

18. Funeral director W.C. Mattingly Son

Address Leonardtown Md

19. 9/20 19 48  
 (Date rec'd by registrar)

Registrar F.A. Camalier

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 48 at 7:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 19 48 to Sept 18 19 48

and that I last saw him alive on Sept. 18 19 48

Immediate cause of death Bilateral Hypostatic

Pneumonia

Other conditions

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Dr. J. H. Patrick MD

Address Lexington Park Md signed 9-18-48

RECEIVED  
SEP 21 1948  
BUREAU V. S.

RECEIVED  
SEP 21 1948  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09665

Reg. Dist. No. 159

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Cross Keys, Harmanville, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's  
City or town Hollywood  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Infant Girl Herbert (Kelley)

### 3. (b) Social Security Number

4. Sex female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced single

B. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) September 10, 1948 6. (c) If alive, give age 19 years

8. AGE: Years 0 Months 0 Days 5 If less than one day hrs. min.

9. Birthplace Maryland -  
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Joseph Herbert

13. Birthplace Maryland

14. Maiden name Bertha A. Kelley

15. Birthplace Maryland

16. Informant Joseph Herbert

Address Hollywood, Md.

17. Burial Date thereof 9-15-48  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Holy Face

Location Great Mills

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 9-14-48 1948 Cavalier  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1948 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/14 1948 to 9/14 1948

and that I last saw him alive on 9/14 1948

Immediate cause of death Pneumonia

Due to Premature birth

8 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. L. Thompson

Address Lexington Park

Date signed 9/15/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

SEP 27 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County St. Mary'sCity or town W-ynn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County St. Mary'sCity or town W-ynn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice Augusta Lewis

## 3. (b) Social Security Number

4. Sex female5. Color or race white6. (a) Single, married, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 10, 1864

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

84416

hrs.

min.

9. Birthplace

Virginia  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 9/28/48

(Date rec'd by registrar)

19. 9/28/48

(Date rec'd by registrar)

19. 9/28/48

(Date rec'd by registrar)

19. 9/28/48

(Date rec'd by registrar)

19. 9/28/48

(Date rec'd by registrar)

19. 9/28/48

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 26, 1948 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 23, 1948 to Sept 26, 1948and that I last saw him alive on Sept 25, 1948

Immediate cause of death

Cerebral hemorrhage

Due to

General arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

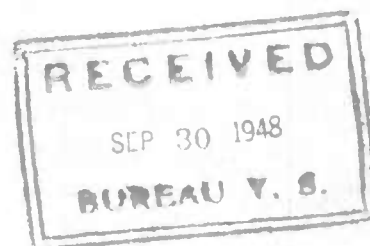
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



RECEIVED

SEP 30 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 09667 256

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Burial at sea  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County St. Mary's  
 City or town Burial at sea  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Howard Jerome Mattingly  
 4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

B. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) July 3 4 1909  
 8. AGE: Years 39 Months 1 Days 29 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 6.(c) If alive, give age \_\_\_\_\_ years

9. Birthplace Compton St. Mary's md  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_

12. Name Donald Mattingly  
 13. Birthplace St. Mary's, Md  
 14. Maiden name May Evelyn Pope  
 15. Birthplace Compton St. Mary's md

16. Informant John Thomas Mattingly  
 Address Compton St. Mary's md  
 17. Burial Date thereof 9-23-45  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory St. Francis Xavier  
 Location Compton St. Mary's md

18. Funeral director M. C. Mattingly  
 Address In action

19. 9-23-45 RM. T. Calver  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1945 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from home 1945 to Sept 23 1945  
 and that I last saw him alive on 21 Sept 45 1945

Immediate cause of death aortic regurgitation  
 (Due to Rheumatism also)  
 Due to Sudden

## DURATION

10 yrs.

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

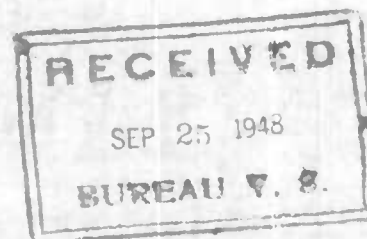
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE RM. T. Calver M. D. or other \_\_\_\_\_  
 Address Burial at sea Date signed 9-23-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Leonardtown Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred  
St Marys Hospital  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St Marys  
 City or town near Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Albert Price

## 3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6.(a) Single, married, widowed, or divorced Single

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 1 - 1908 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 39 Months 4 Days 5 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace near Leonardtown St Marys Md  
 (town, county, and state)

10. Usual occupation Laborer

11. Industry or business same

12. Name John Price

13. Birthplace St Marys Co

14. Maiden name Ann Pauline Nelson

15. Birthplace St Marys Co

16. Informant Mrs Ann Pauline Price

Address Leonardtown Md

17. Buried Date thereof Sept 7, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Alphonsius Cemetery

Location near Leonardtown Md

18. Funeral director W.C. Mattingley Sons

Address Leonardtown Md

19. 9-8-48 19 48 Dr. F. B. Canahin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 19 48 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2nd 1948 to Sept 5th 1948

and that I last saw him alive on Sept 5th 1948

Immediate cause of death Septic shock Hemorrhage

Due to apparently to a blow or fall

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

(Include pregnancy within 3 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F. P. Greenwell MD

Address Leonardtown Md Date signed 9-5-48

RECEIVED

SEP 10 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 286

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Rural Palmyra  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? all his life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County St. Mary's  
City or town Rural Palmyra  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

May Frances Thompson

### 3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 9-19-1926 6. (c) If alive, give age 19 years

8. AGE: Years 27 Months 11 Days 22 If less than one day hrs. min.

9. Birthplace Palmyra St. Mary's Md  
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business Teacher for 20 yrs.

12. Name Leon and Allan Thompson

13. Birthplace Palmyra Md

14. Maiden name May Edith Walling

15. Birthplace Palmyra Md

16. Informant Leon and Allan Thompson

Address Palmyra Md

17. Burial Date thereof 9-13-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Bushy Mt. Rd

18. Funeral director Mc Walling & Son

Address Leon and Allan Thompson

19. 9-11- 19 48 H. V. Palmer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10- 19 48 at 11 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-3- 19 48, to 9-10- 19 48  
and that I last saw him alive on 9-10- 19 48

Immediate cause of death Pleurisy

### DURATION

62

Due to Chronic bronchitis

Due to Exhaustion

Other conditions Infantile paralysis 20 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer

M. D. or other

Address Palmyra Md Date signed 9-11-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 17 1948  
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 288

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Valley Lee, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James William Travers

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary C. Travers

7. Birth date of

deceased (mo., day, yr.)

July 5, 1886

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

62

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

Unknown

MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

James G. Travers

Address

Princess Point, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

9-8-48

(month) (day) (year)

Cemetery or crematory

St. Marks

Location

Valley Lee, Md.

18. Funeral director

J. B. Robinson

Address

Leonardtown, Md.19. 9-18

(Date rec'd by registrar)

19. 48Coroner

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Princess Point  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1948 at 7:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Death when first seen. 19..... to 19.....

and that I last saw him..... alive on ..... 19.....

Immediate cause of death

DURATION

Extreme Head injuryImmediate

Due to

Trauma.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/6/48Where did injury occur? Valley Lee, St. Mary's, Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) HighwayMeans of injury Auto accident Injured at work? no23. SIGNATURE William L. Robinson

M. D. or other

Address Leonardtown, Md. Date signed 9/6/48

RECEIVED

SEP 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County... St. Mary's Co.  
 City or town... Patuxent Naval Air Base  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? St. Mary's Hospital 11 days

## 3. (a) FULL NAME

Rosa Mathilda Emily Kader Ude

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Otto Ude

7. Birth date of deceased (mo., day, yr.)

Jan. 1st 1897

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

51916

hrs.

min.

9. Birthplace

StuttgartGermany

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden name

From Mrs. Mathilda Kader

15. Birthplace

Germany

16. Informant

R. B. Lee A.M.C.

Address

Patuxent River, Md

17.

Cremation

Date thereof

9-20-48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Funeral home or crematory

Cremation - Lanier Funeral Home

Location

2140 North East 2nd Ave. Miami, Florida

18. Funeral director

W. C. Mattingly Sons

Address

Leonardtown, Md

19.

Sept 17 1948

1948

F. A. Cavalier M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Miami Florida

County

Dade

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 16

19

48

at

9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 4

19

48

to

Sept. 15

19

48

and that I last saw him

alive on

September 15

19

48

Immediate cause of death

Acute Myocardial Failure

DURATION

1/2 hrs

Due to

Chronic Myocarditis and myocardial Degenerationover 5 yrs

Due to

Other conditions

Diabetes Mellitusover 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Pericentesis of Abdomen

Date of op.

9/12/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert V. Fuchs, M.D.

M. D. or other

Address

Leonardtown, Md.

Date signed

9/16/48

RECEIVED  
SEP 21 1948  
BUREAU V. S.